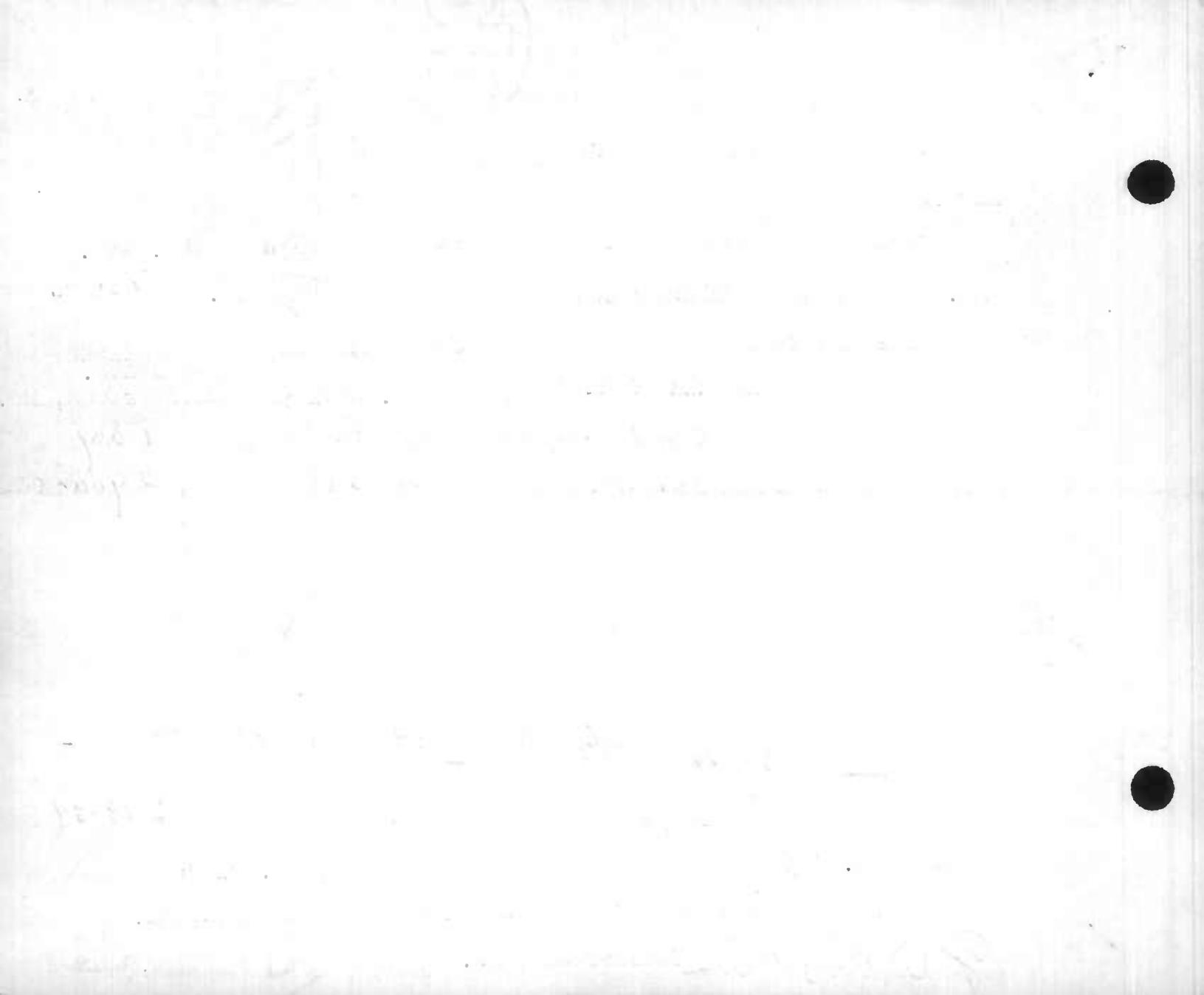


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the time of death. Page 3 should be detached for use as the burial/still permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours of death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/still permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours of death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 / 9 4											
												REG. NO.											
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
			Lillie			May			Angevine						6 17 84			10:40 A.M.					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS								
female			white			Jan 17, 1897			87			YRS			MONTHS DAYS			HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Kent			MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			Stenographer			Vet. Adm.								
Chestertown			Kent and Queen Anne's Hospital									High St.			21620								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21620								
Md.			Kent			Chestertown						High St.			Campus Ave.								
14. FATHER'S NAME			FIRST			LAST			15. MOTHER'S MAIDEN NAME			ADDRESS			LAST								
Solomon Truitt									Josephine Biggs			Rebecca K. Bexley			21620								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE)			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
no			213 818 50 2276																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												Cardiorespiratory failure 1 day											
1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of breast 2 years											
19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			22a. DATE SIGNED														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE																	
22a. I certify that (I) (this hospital) attended the deceased from 6-4, 1984, to 6-17, 1984, that (I) (I) lost soul the deceased, alive on 6-16, 1984, and that in (my) (I) opinion death occurred on the date and hour and from the causes stated above, (I) (I) did not view the body after death.												22b. SIGNATURE Wayne D. Benjamin											
22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												22d. DATE SIGNED 6-18-84											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN COUNTY STATE								
Burial						6/20/84			Chester Cemetery			Chester, Md. 21620											
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE														
J. Willis Wells			Chestertown, Md.			JUN 21 1984																	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1M, RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201, PRIORITY BURIAL CREMATION OR REMOVAL.

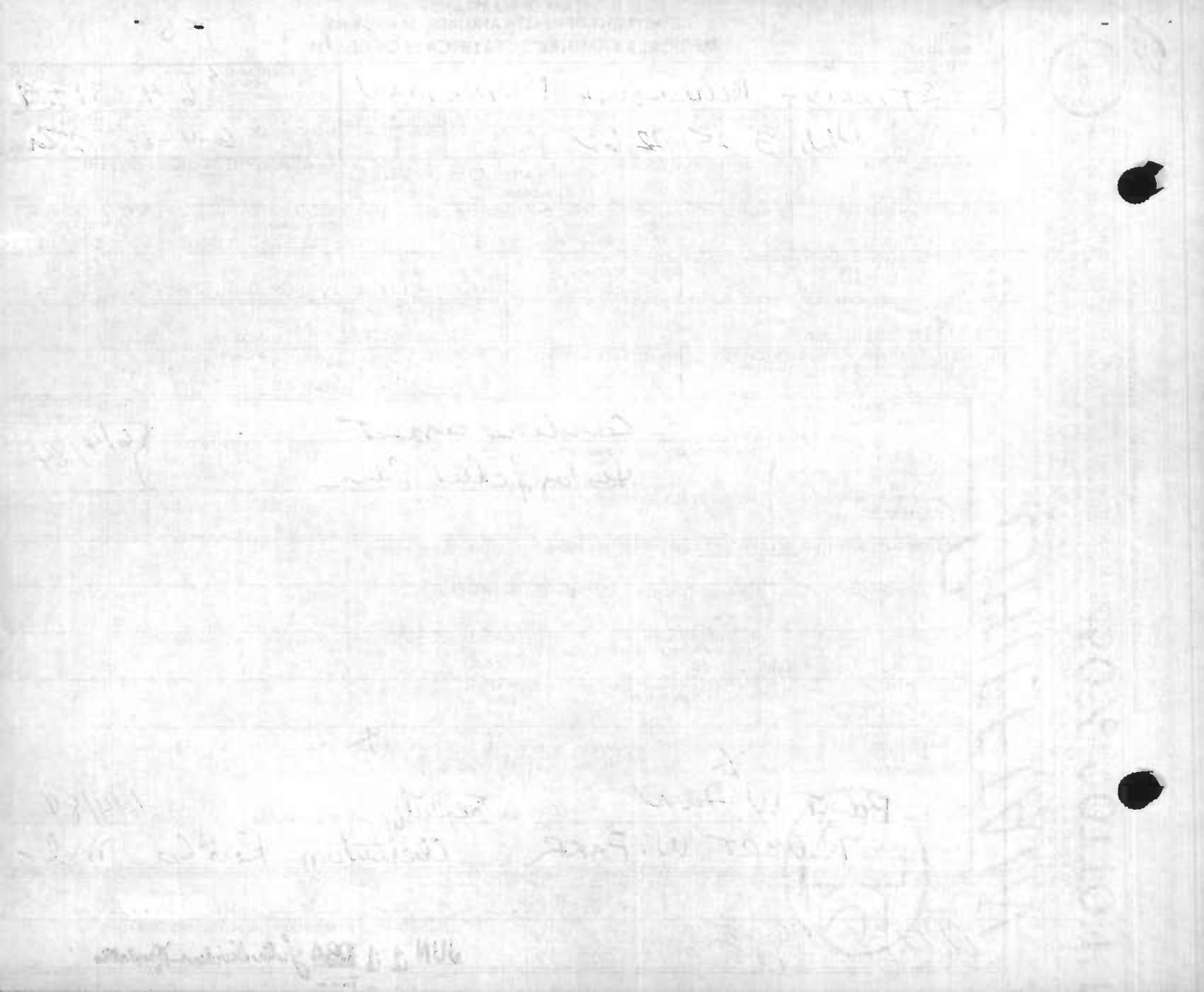
MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

- 6 - 9 5

1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			20. DATE KNOWN OF ESTI- MATED			MONTH DAY YEAR			2b. HOUR	
STIRLING M.			BRINKMAN, SR.						<input checked="" type="checkbox"/> 6 4 1984							
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.		IF UNDER 24 HRS.		21. DATE PRONOUNCED DEAD		MONTH DAY YEAR		22. HOUR		
Male		White	3/26/22		62 yrs.	MONTHS	DAYS	HOURS	MIN.	6-4-84 2:20P		19				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA							Kent							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Chestertown			Kent & Queen Anne Hospital					Rtd/Administrator			SchoolDist					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY	13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
			Md.			Kent	Golts		YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	Rt#1, Box 337, Shorewood Ests.					
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			ADDRESS							
Phillip Brinkman						Elizabeth McCullough			Rt#1, Box 337, Golts, Md.							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Nancy B. Brinkman (Wife)							
Yes WW II			221 10 0874													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
4275 IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) <u>History of chest pain</u> (c)										6/4/84						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?							20. AUTOPSY?						
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE <u>Robert W. Farr</u>										M.D. <u>Deputy</u>		MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT) <u>ROBERT W. FARR</u>										DATE SIGNED <u>6/4/84</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial			6/6/84			Red Clay Cr. Presby Cem.			Wilmington, N. C.		Del.					
24. FUNERAL DIRECTOR NAME <u>Robert W. Farr</u>			ADDRESS			Wilm., Del.			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Albert J. McCrery, VII, 3924 Concord Pk.									JUN 1 1984		<u>Julia Davidson Pendleton</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301-767-5555.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 4 16 / 96		
												REG. NO.		
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Catherine Jane Bullen						6-10-84			6:55 AM		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		Feb. 28, 1907			77			YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD				
Maryland		U.S.A.					Kent							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Chestertown		The Kent & Queen Anne's Hospital, Inc.		Seamstress			Spencers Trailer Park			21620				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE				
Maryland		Kent		Chestertown						Spencers Trailer Park				
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST		
Howard Coleman, Sr.							Helen ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS							
no		218-03-0217		Betty Crouch, Rock Hall, Md 21661										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>Myocardial failure</u>												4 days		
0389 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												4 days		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic</u>														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>6-10</u> , 19 <u>79</u> , to <u>6-10</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>6-10</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Wayne D. Benjamin M.D.</u> DEGREE												22c. DATE SIGNED <u>6-14-84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <u>Chestertown, Md 21620</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>06/13/84</u>			23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN <u>Wesley Chpel Ceme.</u>			23d. LOCATION CITY OR TOWN <u>Rock Hall</u>			COUNTY <u>Kent</u> STATE <u>MD</u>		
24. FUNERAL DIRECTOR NAME <u>Tom Helfenbein Funeral Homes, P.A., Chester, MD</u>												25a. DATE REC'D. BY REGISTRAR <u>JUN 18 1984</u> REGISTRAR'S SIGNATURE <u>Jane D. Benjamin Rendall</u>		
ADDRESS														

page 3
a
1 may be
1000 hours after death
1000 hours after death

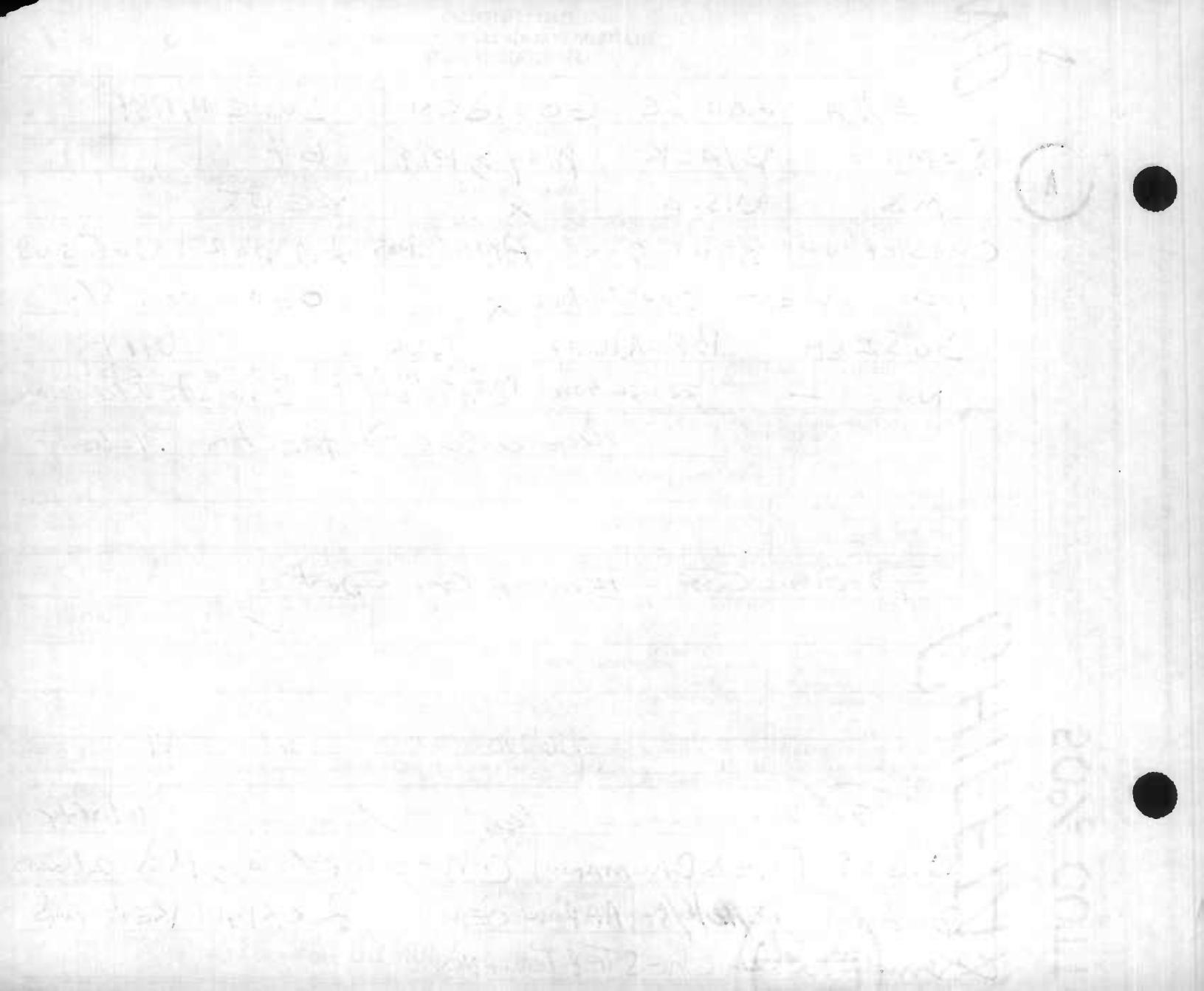


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 16 / 97											
1. FOR STATE REGISTRAR			REG. NO.																				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			20. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
ELIA LOUISE GOULDEN												JUNE 11, 1984						M					
3. SEX FEMALE			4. RACE BLACK			5. DATE OF BIRTH MAY 3 1919			6. AGE (IN YEARS LAST BIRTHDAY) 64			7. IF UNDER 1 YEAR MONTHS			8. IF UNDER 24 HRS HOURS								
7. BIRTHPLACE MD			8. CITIZEN OF WHAT COUNTRY? U.S.A			9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH KENT			10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD. KENT CHESTER TOWNSHIP			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION KENT QUEEN ANNE'S HOSPITAL			12a. USUAL OCCUPATION LABOR					
13a. STATE MD.			13b. COUNTY KENT			13c. CITY OR TOWN CHESTER TOWNSHIP			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 506 CALVERT ST.			12b. KIND OF BUSINESS OR INDUSTRY UNIVERSITY								
14. FATHER'S NAME JOSEPH B. BROADWAY									15. MOTHER'S MAIDEN NAME SUSIE														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-26-9080			17. INFORMANT MR. S. M. PART			17. ADDRESS 506 CALVERT ST. CHESTER TOWNSHIP									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hour					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100						DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Previous CVA - Recurrent Gastroenteritis																							
19a. MEDICAL CERTIFICATION DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from 7/10/70, 19, to 10/11/1984, that (I) (we) last saw the deceased alive on 6/11/1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																							
22b. SIGNATURE E. Baumann						DEGREE LAW			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 6/12/84											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. GOTTFRIED BAUMANN						22e. ADDRESS CHESTER TOWNSHIP, MD. 21620																	
23a. BURIAL, CREMATION, REMOVAL B.C.R.			23b. DATE 6/16/84			23c. NAME OF CEMETERY OR CREMATORIAL AARON CEM.			23d. LOCATION CITY OR TOWN ROCK HALL, KENT, MD.			23e. DATE REC'D. BY REGISTRAR JUN 18 1984			23d. REGISTRAR'S SIGNATURE John D. Baumann								
24. FUNERAL DIRECTOR NAME KENNETH W. CHESTER TOWNSHIP			ADDRESS																				

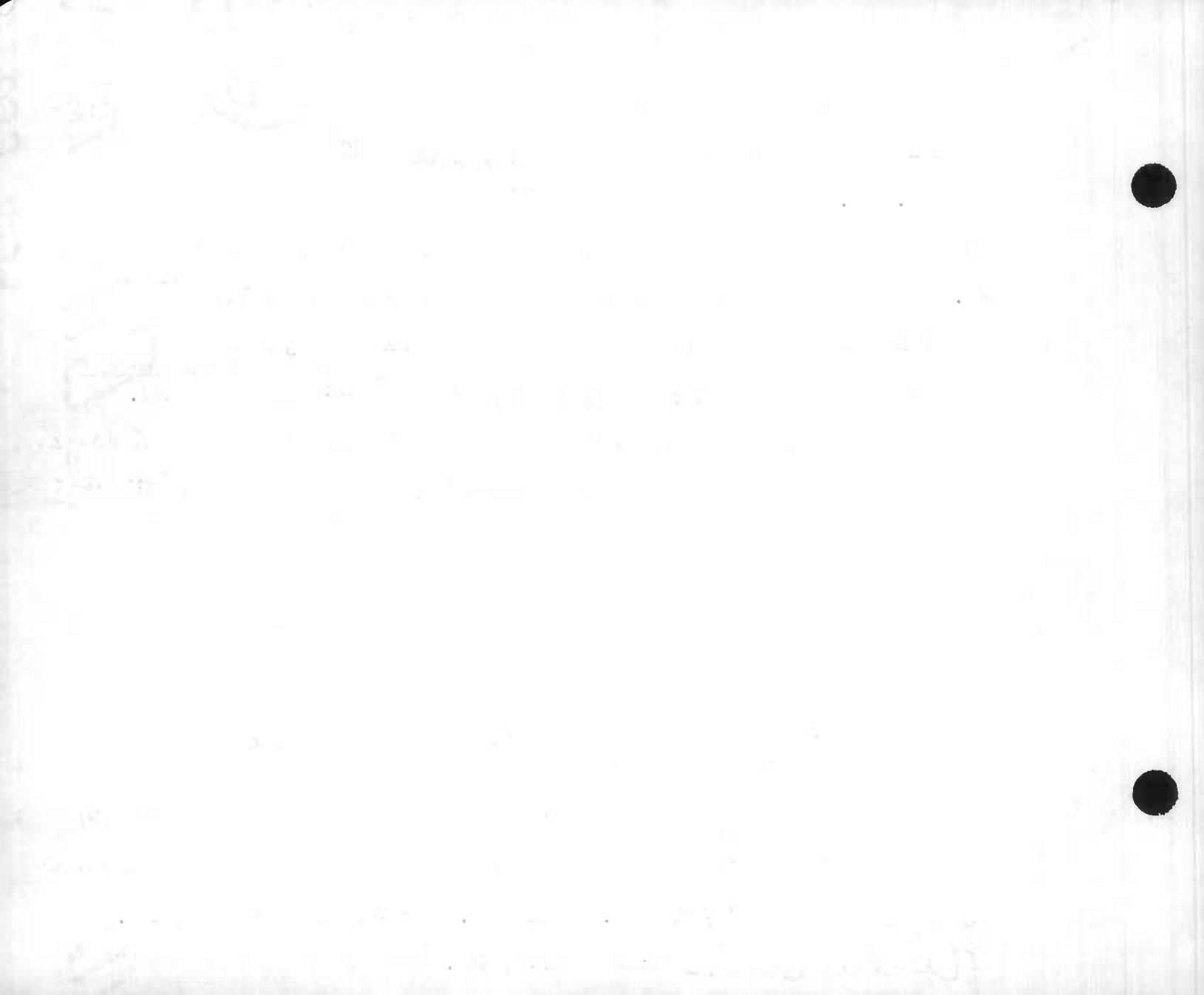


10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or in any way altered, any injury, or other traumatic event, the medical examiner must be notified of once

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 / 9 8			
												REG. NO.			
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Kathleen Northrup Hayes						6/20/84			3:50a m			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
female		white		October 25, 1900			83			MONTHS DAYS		HOURS MIN.			
YRS.															
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Kent Co. Md.		USA						Kent							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Chestertown		The Kent and Queen Anne's Hosp.			Schoolteacher										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			21620		
Md.		Kent		Chestertown						RD # 2 Bx 447					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
First Tilghman		Middle Hubbard			First Della			Middle Jones							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			RD # 2 ADDRESS			Chestertown				
no		221 22 8052			Roy Hayes			Bx 447			Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any												2 days			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>6/15/84</i> Bleeding												4 days			
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>6/15/84</i> to <i>6/15/84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.					6/15/84			6/15/84			19 84		19 84		
22b. SIGNATURE <i>Schreiber</i>					DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>6/20/84</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SCHREIBER</i>					22e. ADDRESS Medical Building, Chestertown, MD 21620										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 6/23/84			23c. NAME OF CEMETERY OR CREMATORIUM St. Paul Cem.			23d. LOCATION near Chestertown, Md.							
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR NAME			25b. REGISTRAR'S SIGNATURE							
Willis Wells					JUN 28 1984						<i>Davidson Pendell</i>				
BP _____															
DHMH - 16 50M 4/83 (VRA 15, 4)															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Part 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Part 2 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours.

IMPORTANT: If item 21 is marked or item 13 shows any injury, or other traumatic event, the medical examiner must be notified with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										84 16799			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
LEONARD Albert Hodges						JUNE 13, 1984							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN				
MALE		BLACK		FEB. 3, 1902		82 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTOMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH				
MD		U.S.A.				QUEENANNE			CHESTER TOWN				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13a. STATE				
A T H O M E R F D #1			LABOR						MD				
13b. COUNTY			13c. CITY OR TOWN			13d. STREET ADDRESS			14. FATHER'S NAME				
Kent			Chester Town			CANNON STREET			FIRST MIDDLE LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT MRS CORINE YORKER			18. CAUSE OF DEATH (Enter only one cause per line 18a, 18b, and 18c) PART 1. DEATH WAS CAUSED BY			ADDRESS	
No			75						Myocardial Infarction			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			1 day							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			Arteriosclerotic vascular disease										
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (1) <input checked="" type="checkbox"/> attended the deceased from Aug. 19, 1984, to 5-10, 1984, that (2) <input type="checkbox"/> last saw the deceased alive on 5-10, 1984, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (1) <input type="checkbox"/> (2) <input type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE		DEGREE										22c. DATE SIGNED	
Wayne D. Benjamin - M.D.												6/14/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
Wayne D. Benjamin		22e. ADDRESS										chester town, MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIAL)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE			
S.D.A. I		6/18/84		EMMANUEL CEM.		CHESTER TOWN		KENT		MD			
24. FUNERAL DIRECTOR		ADDRESS										25a. DATE REC'D. BY REGISTRAR	
Kenneth Wells		chester town										JUN 21 1984	
25b. REGISTRAR'S SIGNATURE													

A

requires that the death certificate be executed within 24 hours of death. Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the "72 hours of death" with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event the medical examiner must be notified at once.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

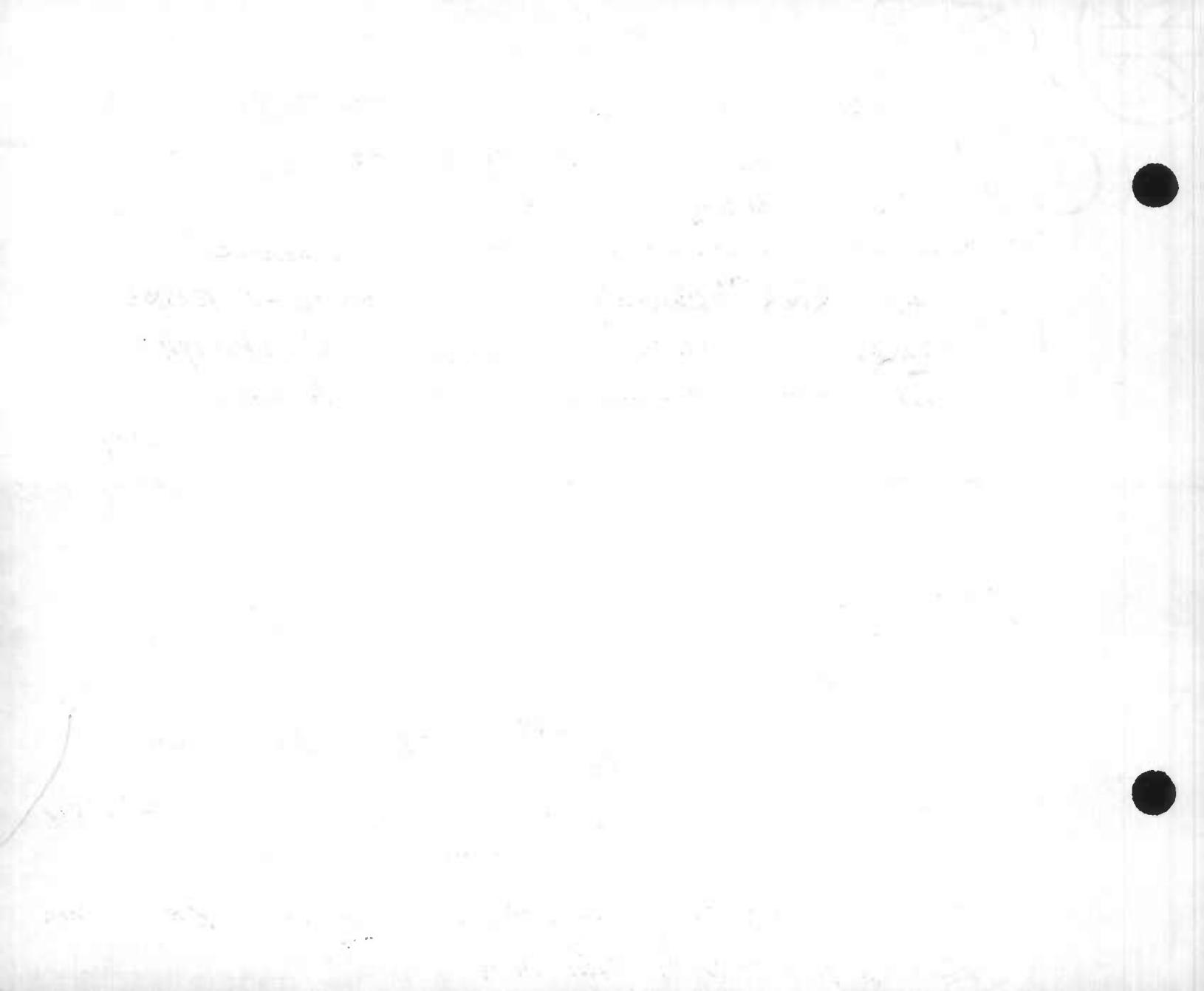
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 6 8 0 0

REG. NO

1. DECEASED NAME (TYPE OR PRINT) Carrie Reafus Hynson			2a. DATE OF DEATH MONTH DAY YEAR June 11, 1984	2b. HOUR 11:55 M
3. SEX Female	4. RACE BLK	5. DATE OF BIRTH MONTH DAY YEAR 10 31 00	6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital INC		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domest. c
13a. STATE MD		13b. COUNTY Kent & Churchill		13c. CITY OR TOWN Route #1 Boxes 21623
14. FATHER'S NAME FIRST MIDDLE LAST James Wilson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lizzy Baldbaugh		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO
16b. SOCIAL SECURITY NO. 219-02-7004		17. INFORMANT Charles Hynson		16c. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hours
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA - massive DUE TO, OR AS A CONSEQUENCE OF (b) Advanced ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>way</i>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>6/11/84</u> to <u>1973</u> , to <u>6/11/84</u> , 1984, that (I) (we) lost saw the deceased alive on <u>1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <u>view</u> the body after death.				
22b. SIGNATURE CG Baumann		DEGREE Res	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 6/11/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CG Baumann		22e. ADDRESS CHARTER OWN, MD		
23a. BURIAL, CREMATION, REMOVAL REMOVED	23b. DATE 6/15/84	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Hope-Pascville	23d. LOCATION CITY OR TOWN Hope	COUNTY STATE 8A MD
24. FUNERAL DIRECTOR NAME Lynn H. Deswell	ADDRESS 100 E. Main St.	25a. DATE REC'D. BY REGISTRAR JUN 21 1984	25b. REGISTRAR'S SIGNATURE Lynn H. Deswell	

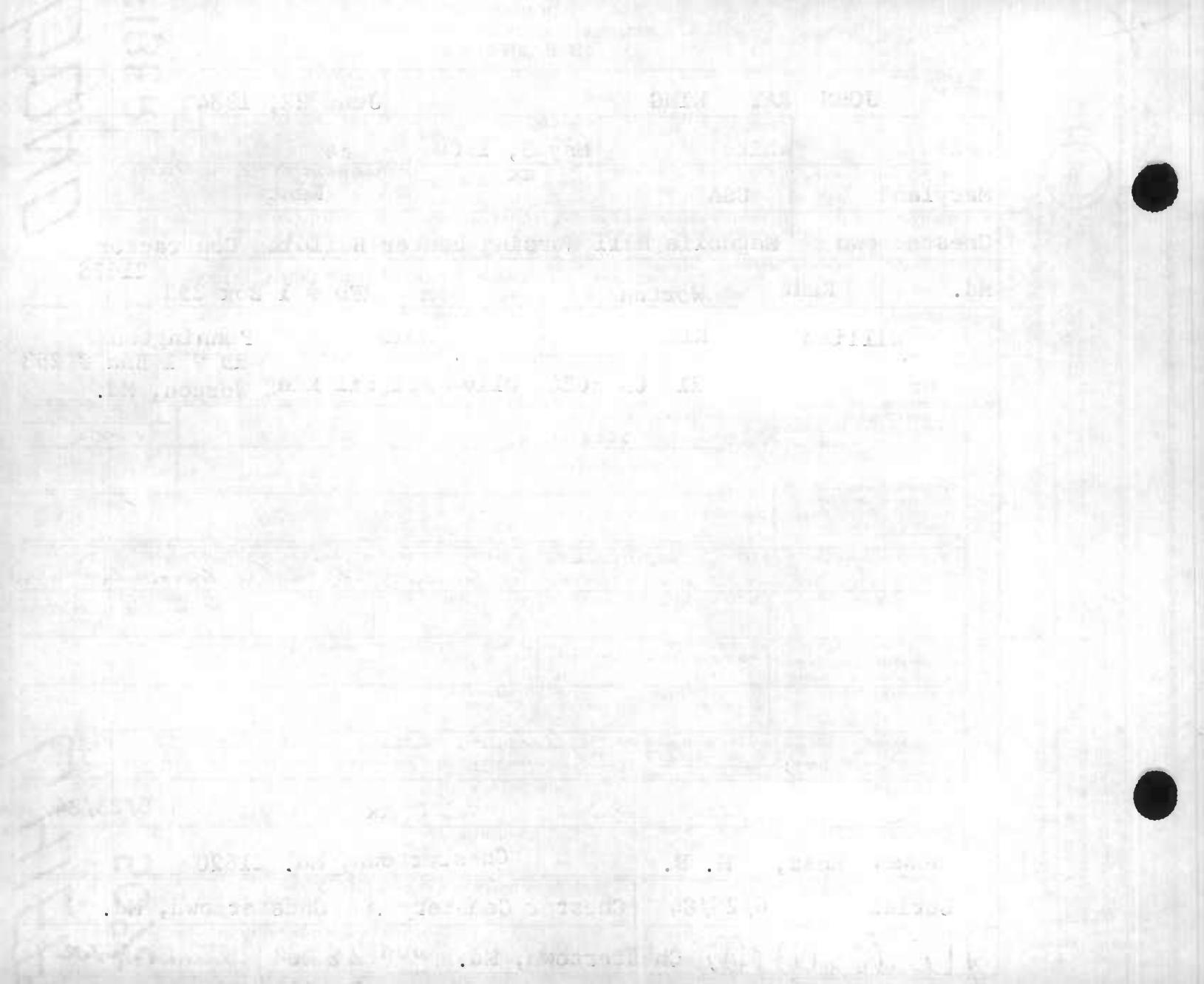


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be
rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3
should be detached for use as the burial/tissue permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours of the death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 310-732-1700.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8416801										
										REG. NO.										
1. FOR STATE REGISTRAR			2. DECEASED NAME (TYPE OR PRINT)			3. FIRST JOHN			4. MIDDLE RAY			5. LAST KING			6. DATE OF DEATH MONTH DAY YEAR			7b. HOUR 7 M		
7. SEX male			8. RACE white			9. DATE OF BIRTH MONTH DAY YEAR			10. AGE (IN YEARS LAST BIRTHDAY)			11. IF UNDER 1 YEAR MONTHS DAYS			12. IF UNDER 24 HRS HOURS MIN.					
13. BIRTHPLACE COUNTRY Maryland			14. CITIZEN OF WHAT COUNTRY? USA			15. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			16. BALTIMORE CITY OR COUNTY OF DEATH Kent			17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			18. KIND OF BUSINESS OR INDUSTRY					
19. CITY OR TOWN OF DEATH Chestertown			20. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			21. 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) THE STATE Md.			22. 13b. 13c. 13d. 13e.			23. STREET ADDRESS / ZIP CODE RFD # 1 Box 253			24. 21678					
25. FATHER'S NAME FIRST William			26. MIDDLE King			27. LAST			28. MOTHER'S MAIDEN NAME FIRST Dora			29. MIDDLE Pennington			30. LAST					
31. 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			32. 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			33. 17. INFORMANT ADDRESS			34. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			35. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			36. 213 05 5024					
37. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.			38. DUE TO, OR AS A CONSEQUENCE OF (b)			39. DUE TO, OR AS A CONSEQUENCE OF (c)			40. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. Orbital Brain Syndrome, Arteriosclerotic Cardiovascular Disease						1 week					
41. MEDICAL CERTIFICATION 19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			22a. YES <input type="checkbox"/> NO <input type="checkbox"/>			22b. YES <input type="checkbox"/> NO <input type="checkbox"/>								
23a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			23b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			23c. LOCATION STREET			24a. CITY OR TOWN			24b. COUNTY			24c. STATE					
25a. I certify that (I) (this hospital) attended the deceased from <u>Aug 12, 1984</u> to <u>Aug 22, 1984</u> , that (I) (we) last saw the deceased alive on <u>Aug 17, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.															26. DATE SIGNED 6/23/84					
27a. SIGNATURE Susan Ross, M.D.			27b. DEGREE			27c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			27d. ADDRESS			27e. ADDRESS			27f. ADDRESS					
28a. PHYSICIAN'S NAME (TYPE OR PRINT) Susan Ross, M.B.			28b. ADDRESS			28c. ADDRESS			28d. ADDRESS			28e. ADDRESS			28f. ADDRESS					
29a. BURIAL, CREMATION, REMOVAL 15p. Burial			29b. DATE 6/25/84			29c. NAME OF CEMETERY OR CREMATORIAL Chester Cemetery			29d. LOCATION CITY/TOWN Chestertown, Md.			29e. COUNTY Chestertown, Md.			29f. STATE					
30a. FUNERAL DIRECTOR NAME J. Willis Wells			30b. ADDRESS Chestertown, Md.			30c. DATE REC'D. BY REGISTRAR JUN 29 1984			30d. REGISTRAR'S SIGNATURE Julia Davidson-Randall			30e. ADDRESS			30f. ADDRESS					



Item 5 per ph. 6/5/84 kg

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 4 1 6 8 0 2

REG. NO.

FOR
1 - STATE
REGISTRAR

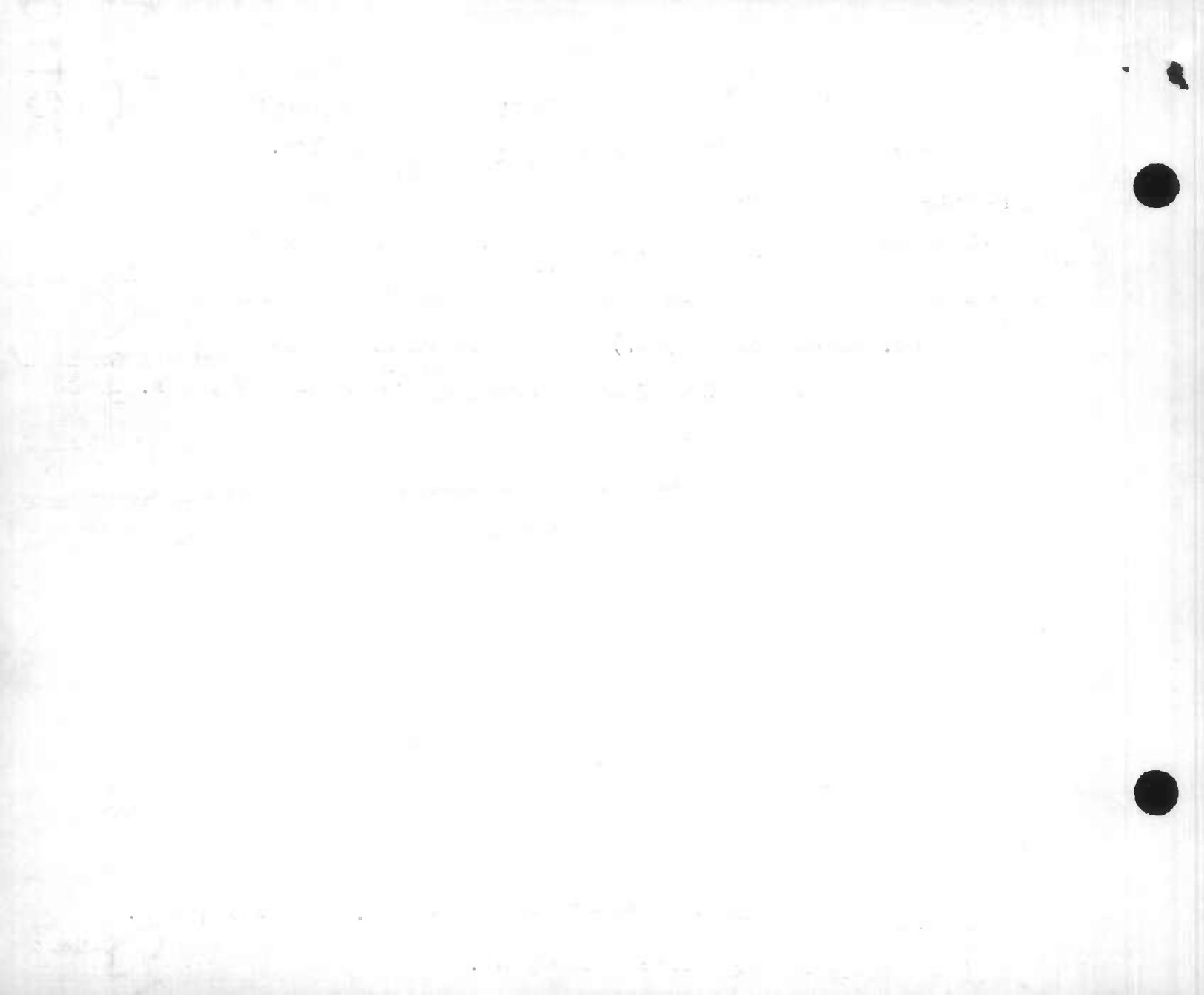
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			William	Bryan	Price III	June 8, 1984				4:48 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Male		White		MONTH	DAY	YEAR	24 Yrs.	MONTHS	YEARS	MONTHS	HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Maryland		USA				Kent					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Chestertown		Kent & Queen Anne's Hospital				Laborer		Various			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE		19938	
Delaware		Kent		Clayton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RD # 1 Bx 1572		99499	
14. FATHER'S NAME		FIRST		MIDDLE		15. MOTHER'S MAIDEN NAME		16. STREET ADDRESS		LAST	
		Wm.		Bryan Price (Jr.)		Patricia Faulkner		Rd # 1 Bx 1572			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		17. ADDRESS		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
no		218 70 4647		Mother		Patricia Price Clayton, Del. 19938		months			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Respiratory Failure											
7599											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Severe Restrictive Lung Disease & Cor Pulmonale											
years											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
(c) Congenital Acid Maltase Deficiency & Muscular Dystrophy											
years											
Disease											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>											
22a. I certify that (I) (this hospital) attended the deceased from 6/7, 1984, to 6/8, 1984, that (I) (we) last saw the deceased alive on 6/7, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE DEGREE											
Susan K. Ross MD											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				22f. DATE SIGNED					
Susan K. Ross MD		516 Washington Avenue, Chestertown, MD.				6/8/84					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY, TOWN		23e. STAFF			
Burial		6/10/84		Emmanuel Church Cen.		Cheswold, Del.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
J. Willis Wells		Chestertown, Md.		JUN 12 1984		Julia Davidson-Fendall					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the death and burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or checked, then please remove carbon paper. Page 3 should be retained by the hospital or attending physician.

99499
BP
DHMH - 16 50M 4/83
(VRA 15, 4)



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as "Yes" to any injury, or other traumatic event, the medical examiner must be notified at 301-576-2333.

PAGE 3
hours after death

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4 1 6 8 0 3		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
Mattie			NMN	Queen		6-4-84						9:03 P
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		BLACK		Aug. 8, 1896		87			MONTHS	YEARS	MONTHS	HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD			
Md		U.S.A.				Kent						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Chestertown		The Kent & Queen Anne's Hospital,		12c. LABOR								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		21663		
Md		Queen Anne Church Hill						NEW STREET				
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST				
JAMES			QUEEN	JENNIE				C N K.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT YES			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		-		MRS. ROCHANDY Rd 61x, Md.						6 mos		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASCO - massive edema</u>												
4292 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from 6/1/1984 to 6/1/1984, that (I) (we) last saw the deceased alive on 6/1/1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>C. Gottfried Bauman</u>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 6/16/84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C. Gottfried Bauman</u>		22e. ADDRESS chesertown, Md. 21620										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Bur. & Crem.		23b. DATE June 9, 1984		23c. NAME OF CEMETERY OR CREMATORIUM BETHESDA CEM.		23d. LOCATION CITY OR TOWN Chesertown, Md.		COUNTY		STATE		
24. FUNERAL DIRECTOR <u>James W. W. Chester</u>		25a. DATE REC'D. BY REGISTRAR JUN 18 1984		25b. REGISTRAR'S SIGNATURE <u>John W. W. Chester</u>								
NAME ADDRESS												

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE
HEALTH DEPT.

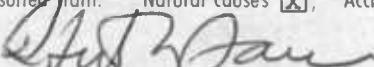
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8 4 1 6 3 0 4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P.M. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be forwarded as a burial-transit permit file page, and in any event within 24 hours after death.

Health Dept. to burial, cremation, or removal

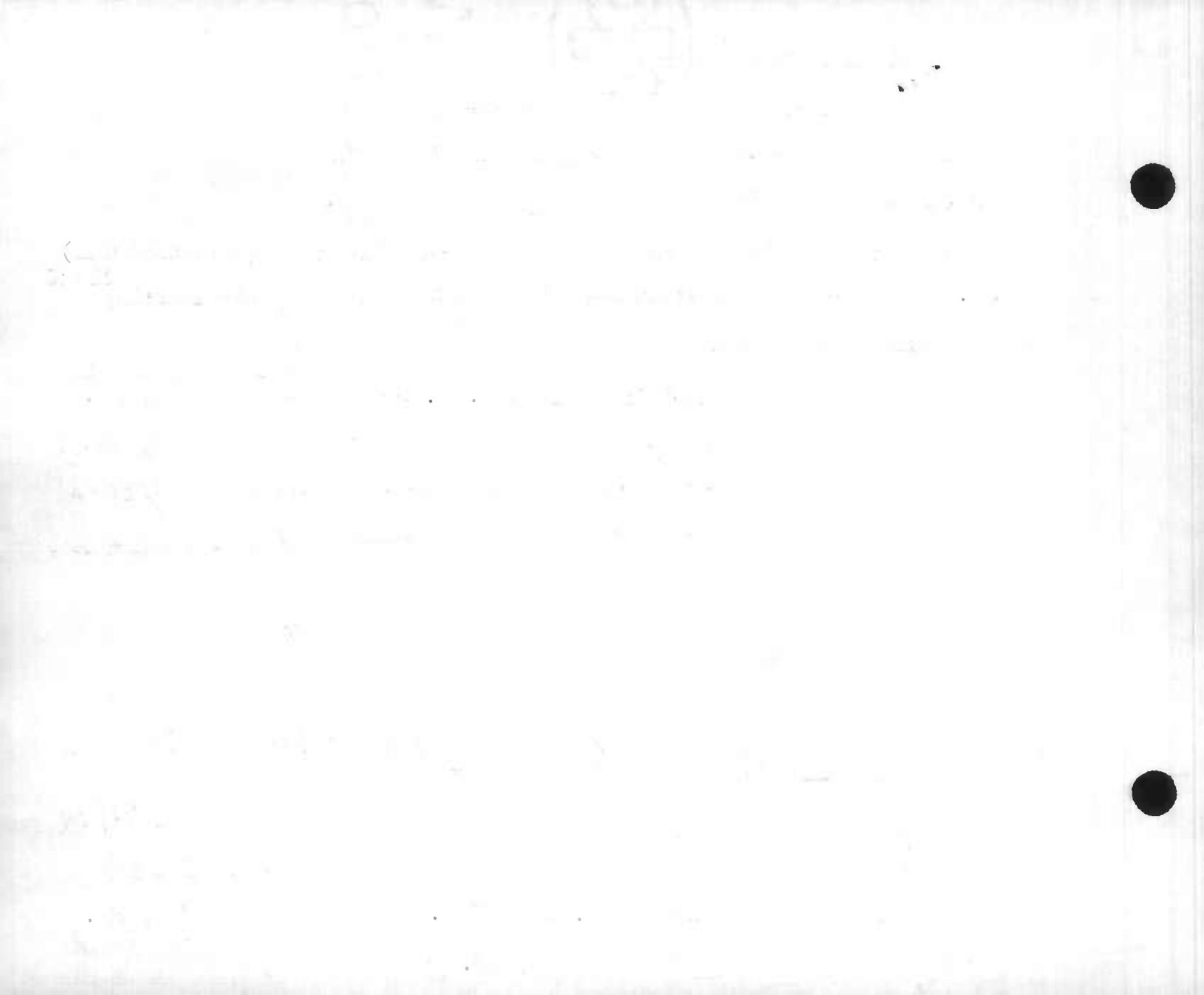
1. DECEASED NAME (Type or Print)	First EARL	Middle LEVI	Last RANSOM	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 6-14	Day 1984	Year M	2b. HOUR 1:10M			
3. SEX MALE	4. RACE CAUC	5. DATE OF BIRTH MARCH 2, 1922	6. AGE (in years at birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS 62	IF UNDER 24 HRS DAYS 0	IF UNDER 24 HRS HOURS 0	IF UNDER 24 HRS MIN. 0	2c. DATE PRONOUNCED DEAD Month JUNE	Day 18	Year 1984	2d. HOUR 1:10M
7a. BIRTHPLACE (State or foreign country) DELAWARE	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED	9. COUNTY OF DEATH KENT								
10. CITY OR TOWN OF DEATH CHESTERTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give address) QUEEN ST.	12a. USUAL OCCUPATION (Kind of work done during working life, even if retired.) PAINTER	12b. KIND OF BUSINESS OR INDUSTRY SELF								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD	13b. COUNTY KENT	13c. CITY OR TOWN CHESTERTOWN	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 112 QUEEN ST							
14. FATHER'S NAME FLOYD SAMUEL RANSOM	First MIDDLE LAST	15. MOTHER'S MAIDEN NAME MARY ETTA COX									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 219-10-5092	17. INFORMANT 44008 Cooper St. Earl Ransom (son) Albany GA 31705	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> last. (b) <u>Probable Obstructive Pulmonary Disease</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE 	CHIEF MEDICAL EXAMINER <input type="checkbox"/>										
EXAMINER'S NAME (Type) Dr. Robert Farr	M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										
22b. DATE SIGNED 6-22-84											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ADDRESS (Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE JUNE 21, 1984	23c. NAME OF CEMETERY OR CREMATORIUM GALENA CEM.	23d. LOCATION (City or Town) (County) (State) GALENA, KENT, MARYLAND								
24. FUNERAL DIRECTOR FELLOWS F.H. BOX 270 MILLINGTON, MD 216	ADDRESS JUL 03 1984	25a. REC'D BY REGISTRAR Julia Davidson-Randall	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4	6 8 0 5				
1. FOR STATE REGISTRAR		Richard Topfstedt				REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST Richard	MIDDLE NMN	Topfstedt		2a. DATE OF DEATH		MONTH JUN	DAY 21	YEAR 1984	2b. HOUR 1:25a M				
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH APRIL DAY 16 YEAR 1893		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS 91 YRS		IF UNDER 24 HRS MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent									
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent and Queen Anne's Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer (Standard Oil)		12b. KIND OF BUSINESS OR INDUSTRY 21620									
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RFD Chesapeake Landing							
14. FATHER'S NAME FIRST Albert		MIDDLE Topfstedt	LAST	15. MOTHER'S MAIDEN NAME FIRST Not Known		MIDDLE	LAST								
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 170 01 7671		17. INFORMANT Geo. U. Howeth		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hrs		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction Arteriosclerotic heart disease years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) () attended the deceased from 10-20, 1979, to 6/19, 1984, that (I) () last saw the deceased alive on 6/19, 1984, and that in (my) () opinion death occurred on the date and hour and from the causes stated above, (I) () (did) (did not) view the body after death.										22c. DATE SIGNED 6/18/84					
22d. SIGNATURE Wayne D. Benjamin		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>							
22e. ADDRESS Chestertown, Md 21620															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE June 23, 1894		23c. NAME OF CEMETERY OR CREMATORIY St. Paul Cem.		23d. LOCATION CITY OR TOWN near Chestertown, Md.									
24. FUNERAL DIRECTOR NAME J. Willis Wells		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR JUN 21 1984		25b. REGISTRAR'S SIGNATURE John Dawson-Pendleton									



TO HOSPITAL OR MEDICAL CENTER OR ATTENDING PHYSICIAN

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached from this form and mailed to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

ge 4 may be filled in by the funeral director. Item 2 should be filled within 72 hours after death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 4 1 6 3 0 6				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST		2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Anna			Elizabeth	Walbert			6-17-84						6:30 P.M.	
3. SEX			4. RACE	W	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			Caucasian		MONTH	DAY	YEAR	93			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Md.			U.S.A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Kent			Housewife				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			Home				
Chestertown			The Kent & Queen Anne's Hospital, Ins.		BARCLAY		P.O. Box 53			21607				
13. STATE			14. COUNTRY		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE			APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH				
Md.			QA.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. MOTHER'S MAIDEN NAME							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			1913 MICHAEL CT. VIRGINIA BEACH				
No			214-76-2674		WESLEY ROYSTON WALBERT		C.V.A.			VA. 23454				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease.</u>		DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>5-14-84</u> to <u>19-6-1984</u> , that (I) (we) last saw the deceased alive on <u>6-17-84</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) (we) <input type="checkbox"/> (did not) view the body after death.														
22b. SIGNATURE			AC. DICK M.D.		DEGREE			22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			6-28-84						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN						
Burial			6/20/84		CHESTER CEMETERY			CHESTERTOWN KENT MD.						
24. FUNERAL DIRECTOR NAME			25a. ACCIDENT REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Marvin V. Willis Jr. CHESTERTOWN MD.			JUN 28 1984		John D. Johnson									

TO HOSPITAL OR ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Form 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Form 3 should be deposited for use at the funeral parlor. Then please return carbon paper, pencil, and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial or cremation.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner should be informed at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 9:03 A.M.			
John Ackburn Wallace									6 28 84						
3. SEX Male		4. RACE Cal.		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE IN YEARS LAST BIRTHDAY 84			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7. BIRTHPLACE COUNTRY Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co. MD.								
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Annes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Telephone Ser.			12b. KIND OF BUSINESS OR INDUSTRY Telephone								
13. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14. STATE Md.		13b. COUNTY Q.A.		13c. CITY OR TOWN Sudlersville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Church St. 21668					
14. FATHER'S NAME John		15. MOTHER'S MAIDEN NAME Wallace		16. SOCIAL SECURITY NO. No			17. INFORMANT Lester Wallace			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 years					
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		18b. SOCIAL SECURITY NO. No		18c. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			18d. DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebrovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
18e. DUE TO, OR AS A CONSEQUENCE OF (c)		18f. DUE TO, OR AS A CONSEQUENCE OF (d)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> 19 75 to <u>6/28 1984</u> , that (I) (we) last saw the deceased alive on <u>6/28 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>C. G. Morris</u>			22c. DEGREE M.D.			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>7/26/84</u>						
22f. PHYSICIAN'S NAME (TYPE OR PRINT)			22g. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 7-2-84			23c. NAME OF CEMETERY OR CREMATORIAL Millington Cem.			23d. LOCATION CITY OR TOWN Millington			COUNTY Kent	STATE Md.		
24. FUNERAL DIRECTOR NAME Edward Fellows & Son Millington, Md.														25a. DATE REC'D. BY REGISTRAR JUL 30 1984	
														25b. REGISTRAR'S SIGNATURE <u>Laura Davidson-Randall</u>	

TO HOSPITAL (or attending physician) The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death.

IMPORTANT: If item 21 is marked on item 18, then any injury, or other traumatic event, the medical examiner must be notified of it.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 4 1 6 8 0 8	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Verma			Della	Warner		June 11, 1984						9:40P.M.	
3. SEX female			4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	IF UNDER 24 HRS		
				February 10, 1905			79			YEARS	MONTHS DAYS	HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Kent Co. Md.			USA						Kent				
10. CITY OR TOWN OF DEATH Chestertown			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital, Inc.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.			13b. COUNTY Kent			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE Morgnec Village			21620	
14. FATHER'S NAME FIRST John T. Cox			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Vermadella Culley			MIDDLE	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 12 0183			17. INFORMANT Harvey Brown			ADDRESS Rock Hall, Md.			21661	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.</u>													
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Longstanding coronary artery disease</u>												COPAS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Severe Diarrhealitis, possible sepsis, anemia</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <u>6/12/84</u> , 19 <u>84</u> , to <u>6/11</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>6/14</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 6/14/84	
22b. SIGNATURE <u>C. M. Hoffer</u>			22d. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C. M. Hoffer</u>			22f. ADDRESS Wesley Chapel Cem.										
23a. BURIAL, CREMATION, REMOVAL (IF ANY)			23b. DATE 6/14/84			23c. NAME OF CEMETERY OR CREMATORIAL Wesley Chapel Cem.			23d. LOCATION CITY OR TOWN Rock Hall, Md.			COUNTY	STATE
24. FUNERAL DIRECTOR NAME <u>Willy Wells</u>			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR JUN 14 1984			25b. REGISTRAR'S SIGNATURE <u>Davidson Pendell</u>				

Grace Mae WILE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

6 8 0 9

DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST			DATE KNOWN OF DEATH ESTIMATED		MONTH DAY YEAR			
GRACE M AE WILE					6 24 1984		12 HOURS 10 00 N			
1. SEX	4. R	15. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		16. IF UNDER 1 YR. MONTHS DAYS		17. IF UNDER 24 HRS. HOURS MIN		
Female	White	12-16-1927		86 yrs.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		18. BALTIMORE CITY OR COUNTY OF DEATH		2d. DATE REC'D. BY REGISTRAR		
Arkansas		USA				Kent County		June 24 1984		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Chestertown		Kent & Queen Anne Hospital				Homemaker		--		
13. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
14a. STATE	14b. COUNTY		14c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		99999	
Georgia	DeKalb		Clarkston				953 Creekdale Dr.		30021	
15. FATHER'S NAME										
FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Jack		W.		Fortner		Mattie				
K						K		Humphrey		
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)										
No		--		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
				432-34-5004		Clarkston, Mr. Dennis E. Wile		GA 30021		
								953 Creekdale Dr.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I DEATH WAS CAUSED BY:										
8/29										
IMMEDIATE CAUSE (a) <i>Injuries to abdomen from seat belt</i>										
DUE TO, OR AS A CONSEQUENCE OF <i>with protuberant internal injuries</i>										
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____										
DUE TO, OR AS A CONSEQUENCE OF _____										
(c) _____										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
		05/21/84		Kennedyville, Cut Co. Md.						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion										
death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		Robert W. Farr		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)		Robert W. Farr		ADDRESS		DATE SIGNED 6/24/84				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE		
Burial		6/28/84		Mt. Olive Cemetery		Randallstown		Baltimore MD		
24. FUNERAL DIRECTOR NAME		Loring Byers Funeral Directors, Inc.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
8728 Liberty Rd.		Randallstown, MD		JUN 26 1984		P. Henderson-Rendall				

